		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027359

Facility Name: SENIOR MANOR NURSING CENTER

Address: 223 EAST FOURTH STREET (Number) SPARTA (City) 62286 (Zip Code)

County: RANDOLPH

Telephone Number: (618)443-4411 **Fax #** (618)443-2212

IDPA ID Number: 371119667001

Date of Initial License for Current Owners: 10/01/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MGMT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,320	1
2		Skilled Pediatric (SNF/PED)			2
3	39	Intermediate (ICF)	39	14,274	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	59	21,594	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,344	2,530	198	4,072	8
9	SNF/PED					9
10	ICF	8,404	2,393		10,797	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,748	4,923	198	14,869	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.86%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 198

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	83,609	4,260	4,849	92,718		92,718		92,718			1
2	Food Purchase		45,460		45,460	787	46,247	(157)	46,090			2
3	Housekeeping	36,879	5,447		42,326	(348)	41,978		41,978			3
4	Laundry	33,926	3,561		37,487		37,487		37,487			4
5	Heat and Other Utilities			37,031	37,031	232	37,263		37,263			5
6	Maintenance	14,575	4,954	14,444	33,973		33,973	589	34,562			6
7	Other (specify):*											7
8	**TOTAL General Services**	168,989	63,682	56,324	288,995	671	289,666	432	290,098			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	476,554	9,963	15,160	501,677	(2,580)	499,097		499,097			10
10a	Therapy	14,309		3,756	18,065		18,065		18,065			10a
11	Activities	14,209	1,256	2,160	17,625	(476)	17,149		17,149			11
12	Social Services	19,867		2,160	22,027		22,027		22,027			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	524,939	11,219	24,736	560,894	(3,056)	557,838		557,838			16
	C. General Administration											
17	Administrative	32,039			32,039	31,080	63,119		63,119			17
18	Directors Fees											18
19	Professional Services			102,802	102,802	(55,936)	46,866	(42,447)	4,419			19
20	Dues, Fees, Subscriptions & Promotions			13,650	13,650	80	13,730	(3,374)	10,356			20
21	Clerical & General Office Expenses	22,804	3,613	24,874	51,291	15,351	66,642	(20,705)	45,937			21
22	Employee Benefits & Payroll Taxes			111,831	111,831	6,261	118,092		118,092			22
23	Inservice Training & Education			445	445		445		445			23
24	Travel and Seminar			3,518	3,518	106	3,624		3,624			24
25	Other Admin. Staff Transportation					859	859		859			25
26	Insurance-Prop.Liab.Malpractice			6,455	6,455	554	7,009		7,009			26
27	Other (specify):*											27
28	**TOTAL General Administration**	54,843	3,613	263,575	322,031	(1,645)	320,386	(66,526)	253,860			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	748,771	78,514	344,635	1,171,920	(4,030)	1,167,890	(66,094)	1,101,796			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SENIOR MANOR NURSING CENTER #0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			15,065	15,065	1,444	16,509	10,391	26,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							10,743	10,743			33
34	Rent-Facility & Grounds			53,400	53,400	2,586	55,986	(53,400)	2,586			34
35	Rent-Equipment & Vehicles			1,302	1,302		1,302		1,302			35
36	Other (specify):*											36
37	**TOTAL Ownership**			69,767	69,767	4,030	73,797	(32,266)	41,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,315	12,922	27,237		27,237		27,237			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,392	32,392		32,392		32,392			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		14,315	45,314	59,629		59,629		59,629			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	748,771	92,829	459,716	1,301,316		1,301,316	(98,360)	1,202,956			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,090	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,605)	21		18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,091)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	306			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,557)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(83,803)	SCHVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (83,803)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (98,360)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

SENIOR MANOR NURSING CENTER

ID# 0027359

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LINE 29 DETAIL	$		1
2	IHCA PAC DUES	(283)	20	2
3	DEFERRED PAINTING SCHXIX-H	589	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	306		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(157)	0	0	0	0	0	0	0	0	0	0	(157)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	589	0	0	0	0	0	0	0	0	0	0	589	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	432	0	0	0	0	0	0	0	0	0	0	432	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(42,447)	0	0	0	0	0	0	0	0	0	(42,447)	19
20	Fees, Subscriptions & Promotions	(3,374)	0	0	0	0	0	0	0	0	0	0	(3,374)	20
21	Clerical & General Office Expenses	(20,705)	0	0	0	0	0	0	0	0	0	0	(20,705)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,079)	(42,447)	0	0	0	0	0	0	0	0	0	(66,526)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,647)	(42,447)	0	0	0	0	0	0	0	0	0	(66,094)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,090	1,301	0	0	0	0	0	0	0	0	0	10,391	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	10,743	0	0	0	0	0	0	0	0	0	10,743	33
34	Rent-Facility & Grounds	0	(53,400)	0	0	0	0	0	0	0	0	0	(53,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,090	(41,356)	0	0	0	0	0	0	0	0	0	(32,266)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,557)	(83,803)	0	0	0	0	0	0	0	0	0	(98,360)	45

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		CANTERBURY MANOR NURSING HOME	WATERLOO	JAMESTOWN MGMT	CARBONDALE	NURSING HOME
		FAIR ACRES NURSING HOME	DUQUION	CORP.		MANAGEMENT
		FAIRVIEW NURSING CENTER	DUQUION			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 98,508	JAMESTOWN MANAGEMENT CORP	32.00%	$ 56,061	$ (42,447)	1
2	V	33	REAL ESTATE TAXES		FOURTH STREET LAND TRUST	100.00%	10,743	10,743	2
3	V	30	DEPRECIATION		FOURTH STREET LAND TRUST	100.00%	1,301	1,301	3
4	V	34	RENT	53,400	FOURTH STREET LAND TRUST	100.00%		(53,400)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 151,908			$ 68,105	$ * (83,803)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	OWNERS COMPENSATION HAS BEEN								$		1
2	ELIMINATED PRIOR TO THE COST REPORT										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JAMESTOWN MANAGEMENT CORP
Street Address: 1001 E MAIN BLDG 4A
City / State / Zip Code: CARBONDALE, IL 62901
Phone Number: ((618)549-8331
Fax Number: ((618)549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 7,064	$	1,779	$ 692	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,367		1,779	232	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440		317,177	317,177	1,023	31,080	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158		1,280		1,779	125	4
5	20	LICENSE & DUES	HOURS OF SERVICE	18,158		816		1,779	80	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718		121,881	121,881	756	11,939	6
7	21	CERICAL & GEN OFFICE EXP	HOURS OF SERVICE	18,158		18,791		1,779	1,841	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158		46,167		1,779	4,523	8
9	24	SEMINARS	HOURS OF SERVICE	10,440		1,077		1,023	106	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440		8,770		1,023	859	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		5,657		1,779	554	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		14,736		1,779	1,444	12
13	34	RENT	HOURS OF SERVICE	18,158		26,400		1,779	2,586	13
14										14
15										15
16		** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN								16
17		ELIMINATED PRIOR TO COST REPORT								17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 572,183	$ 439,058		$ 56,061	25

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	10,743	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,743	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	10,743	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	10,859	8
	1996	10,586	9
	1997	10,496	10
	1998	10,533	11
	1999	10,743	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,936 B. General Construction Type: Exterior MASONRY Frame CONCRETE & WOOI Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	30,000	1970	$ 6,000	1
2					2
3	TOTALS	30,000		$ 6,000	3

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1970	1970	$ 153,542	$	30	$ 2,561	$ 2,561	$ 153,542	4
5	16		1976	1976	51,431		25	2,057	2,057	50,396	5
6			1976	1976	38,320		15			38,320	6
7			1976	1976	7,820		20			7,820	7
8			1976	1976	45,187		25	1,807	1,807	44,271	8
	Improvement Type**										
9	FULLY DEPR(HEAT&AIR COND/NURSES STATION)			1976	30,444		10 YEARS			30,444	9
10	STORAGE BUILDING			1981	1,317		15			1,317	10
11	ROOF			1982	8,430		10			8,430	11
12	ACTIVITY ROOM			1986	21,751	1,208	20	1,088	(120)	15,776	12
13	CONCRETE PORCH & WALK			1988	3,276	218	20	164	(54)	2,050	13
14	BATH & KITCHEN TILE			1989	4,377	292	20	219	(73)	2,518	14
15	REPAIR SHOWERS			1989	548	37	20	27	(10)	311	15
16	4 WALL A/C UNITS			1990	4,893		10	238	238	4,893	16
17	PLUMBING			1990	4,324	137	20	216	79	2,268	17
18	PARKING LOT			1990	9,280	619	15	619		6,499	18
19	CUBICLE TRACK			1990	1,750		10	87	87	1,750	19
20	ELECTRICAL WIRING & FIXTURES			1990	963		20	48	48	504	20
21	ROOF			1991	14,388		20	719	719	6,472	21
22	PHONE SYSTEM			1991	3,243		20	162	162	1,539	22
23	ASPHALT WORK			1991	2,155	144	15	144		1,368	23
24	OFFICE REMODELING			1991	2,541	169	15	169		1,606	24
25	LANDSCAPING			1991	1,548	103	10	155	52	1,472	25
26	MORTON BUILDING			1992	1,992	199	20	100	(99)	850	26
27	FIRE ALARM SYSTEM			1994	3,345	335	10	335		2,177	27
28	PARKING LOT			1994	5,655	377	15	377		2,451	28
29	WATER HEATER			1996	1,680	112	15	112		504	29
30	WALL UNIT HEAT/COOL			1996	915		10	92	92	414	30
31	ARMSTRONG FLOORING IN DINNING			1997	4,976	332	10	498	166	1,743	31
32	NEW GASLINE RAN			1997	945	38	25	38		133	32
33	FIRE EXTINGUISHING SYSTEM ABOVE HOOD			1997	1,578	105	15	105		368	33
34	built cabinets, closet, & computer work station in beauty shop area			1997	4,511	451	10	451		1,579	34
35	NEW FLOORING ROOM 102			1997	749	75	10	75		262	35
36	TOTAL (lines 4 thru 35)				$ 437,874	$ 4,951		$ 12,663	$ 7,712	$ 394,047	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BACKFLOW PREVENTOR ON WATER SOFTNER			1997	601	40	15	40		140	9
10	1 WALL UNIT HEAT/COOL			1997	924		10	92	92	322	10
11	CARPETING AND WALLPAPER DOWN HALLWAYS			1998	6,904	1,208	10	690	(518)	1,725	11
12	WATER HEATER			1998	3,291	576	10	329	(247)	823	12
13	2 GE THRU WALL HEAT/AC UNITS			1998	1,807	316	10	181	(135)	452	13
14	WATER HEATER			1998	3,484	609	10	348	(261)	870	14
15	WATER SOFTNER			1998	1,400	245	10	140	(105)	350	15
16	ROOF REPAIR			1999	8,452		10	845	845	1,268	16
17	SIGN			1999	1,392	139	10	139		209	17
18	SEAL & STRIPE PARKING LOT			1999	1,036	130	8	130		195	18
19	CARRIER A/C UNIT			1999	2,900	290	10	290		435	19
20	new carpet,added interior window, built work top, & clinical record			1999	7,602	760	10	760		1,140	20
21	storage, built water heater surround wall all in nurses office/station										21
22	labor & materials for new sink, flooring, and lighting in priv pay room			1999	1,164	116	10	116		174	22
23	tore out existing wood floor, laid tile on concrete, and wallpapered			1999	4,683	468	10	468		702	23
24	in the kozy knook & dining room										24
25	remove wallpaper, repaired walls, cut off doors, new cove base all in			1999	376	38	10	38		57	25
26	the administrator's office										26
27	LIGHT FIXTURES PUT DOWN HALLWAYS			1999	435	44	10	44		66	27
28	TILE & COVE BASE IN KOZY KNOOK			2000	1,729	58	10	86	28	86	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 48,180	$ 5,037		$ 4,736	$ (301)	$ 9,014	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 76,659	$ 4,496	$ 7,853	$ 3,357	VARIOUS	$ 46,674	37
38	Current Year Purchases	4,063	581	204	(377)	VARIOUS	204	38
39	Fully Depreciated Assets	119,346				VARIOUS	119,346	39
40								40
41	TOTALS	$ 200,068	$ 5,077	$ 8,057	$ 2,980		$ 166,224	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	JAMESTOWN ALLOCATION			$	$ 1,444	$ 1,444	$		$ 8,704	42
43										43
44										44
45										45
46	TOTALS			$	$ 1,444	$ 1,444	$		$ 8,704	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 692,122	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 16,509	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 26,900	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 10,391	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 577,989	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,302 Description: DISHWASHER(828) STORAGE(474)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
   WE ONLY HIRE TRAINED AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3	hrs	$	79	$ 5,095	$	79	$ 5,095	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		11	907		11	907	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		97	6,144	99	97	6,243	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				6,911		6,911	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, medical supplies, Other (specify): lab, and x-ray	39/2 39/3				776	7,305		8,081	13
14	TOTAL			$	187	$ 12,922	$ 14,315	187	$ 27,237	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,541	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	145,014		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	591		5
6	Prepaid Insurance	(853)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): TAX DEPOSITS	1,400		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 157,693	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	111,659		15
16	Equipment, at Historical Cost	132,335		16
17	Accumulated Depreciation (book methods)	(174,073)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,921	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 227,614	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 19,898	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,339		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,162		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LOAN FROM OWNERS	49,000		36
37	401 K LIABILITY	1,347		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 107,746	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 107,746	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 119,868	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 227,614	$	48

***(See instructions.)**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 166,748	1
2	Restatements (describe):		2
3	1999 FEDERAL TAX REFUND	23,296	3
4	1999 STATE TAX REFUND	6,513	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 196,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(76,689)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (76,689)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 119,868	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,196,141	1
2	Discounts and Allowances for all Levels	5,781	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,201,922	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,915	6
7	Oxygen	274	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,189	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	777	19
20	Radiology and X-Ray	72	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 849	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,667	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,667	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,224,627	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	288,995	31
32	Health Care	560,894	32
33	General Administration	322,031	33
	B. Capital Expense		
34	Ownership	69,767	34
	C. Ancillary Expense		
35	Special Cost Centers	27,237	35
36	Provider Participation Fee	32,392	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,301,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	(76,689)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (76,689)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **IL REPLACEMENT T DEDUCTED ON FED**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,803	1,917	$ 35,529	$ 18.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,669	1,817	26,256	14.45	3
4	Licensed Practical Nurses	9,265	9,924	122,121	12.31	4
5	Nurse Aides & Orderlies	29,449	32,134	292,648	9.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,618	1,679	14,309	8.52	8
9	Activity Director	1,777	1,841	14,209	7.72	9
10	Activity Assistants					10
11	Social Service Workers	1,939	2,003	19,867	9.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,484	2,527	24,745	9.79	14
15	Cook Helpers/Assistants	7,489	8,191	58,864	7.19	15
16	Dishwashers					16
17	Maintenance Workers	1,615	1,638	14,575	8.90	17
18	Housekeepers	4,652	4,966	36,879	7.43	18
19	Laundry	3,669	3,960	33,926	8.57	19
20	Administrator	1,992	2,096	32,039	15.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,164	2,253	22,804	10.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,585	76,946	$ 748,771 *	$ 9.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	116	$ 4,849	L1,C3	35
36	Medical Director		1,500	L9,C3	36
37	Medical Records Consultant	21	525	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	L10,C3	39
40	Physical Therapy Consultant	63	3,443	L10A,C3	40
41	Occupational Therapy Consultant	2	119	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	194	L10A,C3	43
44	Activity Consultant	42	2,160	L11,C3	44
45	Social Service Consultant	42	2,160	L12,C3	45
46	Other(specify) DENTAL	12	375	L10,C3	46
47	PURCHASING(820)BILLING(728)		1,548	L19,C3	47
48	MAINTENANCE CONSULTING	1	15	L6,C3	48
49	TOTAL (lines 35 - 48)	350	$ 17,488		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	93	1,902	L10,C3	51
52	Nurse Aides	501	8,909	L10,C3	52
53	TOTAL (lines 50 - 52)	594	$ 10,811		53

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULA MUNSEN	ADMINISTRATOR	0	$ 32,039
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 32,039

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT	MANAGEMENT	$ 98,508
MIKRON	COMPUTER	1,001
ADP	PAYROLL	552
BARNETT & LEVINE	ACCOUNTING	793
MES	PURCHASING CONSULTANT	820
NCS HEALTHCARE	BILLING SERVICE	728
BENEFIT PLANNING CONS.	401 K SERVICES	400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 102,802

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,709
Unemployment Compensation Insurance	12,401
FICA Taxes	57,281
Employee Health Insurance	5,978
Employee Meals	1,738
Illinois Municipal Retirement Fund (IMRF)*	
401 K CONTRIBUTION	943
VACCINES	1,745
JAMESTOWN ALLOCATION	4,523
PARTIES, MERIT, ATTENDANCE, BONUS,ETC	2,774
TOTAL (agree to Schedule V, line 22, col.8)	$ 118,092

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,020
Health Care Worker Background Check	780
(Indicate # of checks performed 65)	
JAMESTOWN ALLOCATION	80
ADMIN LICENSE(75)OTHER ADV(3091)	3,166
DON ASSOC(15)IHCA(2450)IHCA-PAC(28	2,748
SUBSC(281)FRANCISE TX(50)CLIA(150)	481
STAT REP(198)CORP FEE(50)NAGNA(200	2,255
ELIMINATE IHCA PAC DUES	(283)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,091)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,356

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LOCAL MILEAGE	1,227
Seminar Expense	
SEMINAR	2,291
JAMESTOWN ALLOCATION	106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,624

**See instructions.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1994	$ 4,924	3	$ 821	$	$	$	$	$	$	$	$
2	PAINTING	1995	4,781	3	1,594	796							
3	PAINTING	1999	1,768	3			295	589	589	295			
4													
5													
6													
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20	TOTALS		$ 11,473		$ 2,415	$ 796	$ 295	$ 589	$ 589	$ 295	$	$	$

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA 2450**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES IHCA-PAC** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,392**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,738** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SENIOR MANOR NURSING CENTER INC.
RECL FOR PGS 3&4 COLUMN 5 DPA COST REPORT
########
ID#0027359

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	1738	
2	FOOD PURCHASES		1738
	RECL EMPLOYEE MEALS		
10	NURSING & MEDICAL RECORDS	1040	
3	HOUSEKEEPING		1040
	RECL SOAP & SHAMPOO		
21	CLERICAL & GENERAL OFFICE EXP	1571	
10	NURSING & MEDICAL RECORDS		1571
	RECL OFFICE SUPPLIES		
2	FOOD PURCHASES	476	
11	ACTIVITIES		476
	RECL FOOD USED IN ACTIVITIES		
2	FOOD PURCHASES	2049	
10	NURSING & MEDICAL RECORDS		2049
	RECL FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	56061	
19	PROFESSIONAL SERVICES		56061
	FOR BREAKDOWN SEE SCHVIII		